PRINTED: 11/19/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 1/02/10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445457	A. BUILDING _____ B. WING _____	11/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TENNESSEE HEALTH CARE	465 ISBILL RD MADISONVILLE, TN 37354

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification and complaint investigation #'s 26549 and 26685 were completed at East Tennessee Health Care on November 16-18, 2010. No deficiencies were cited related to complaint investigation #'s 26549 and 26685 under 42 CFR Part 482.13, Requirements for Long Term Care Facilities.	F 000	F280 483.20 (d)(3), 483.10 (k)(2) SS=D **Right to Participate Planning Care-Revised CP** **Requirement:** A comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment...	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise the care plan for two residents (#3, and #8) of fifteen residents reviewed.	F 280	**Corrective Actions:** 1a. On 11/17/2010 the facility MDS Coordinator corrected Resident #3's care plan to show resident's POST form signed by resident's Power of Attorney (POA) on August 6, 2010 which revealed "... Do Not Attempt Resuscitate (DNR/no CPR)...". 1b.On 11/17/2010 the MDS Coordinator corrected Resident #8's care plan to show resident as having "bed/chair alarm". 2a. On 11/17–11/30/2010 facility Nurse Management performed audit of POST forms to ensure compliance with care plan documentation. 2b. On 11/17-11/30/2010 Nurse Management performed audit of Pre-Restraint Assessments to ensure compliance with care plan documentation. 3a.On 11/30/2010, the facility Director of Nursing Inserviced MDS Coordinator, facility MDS Assistant, and facility Social Services Director (SSD) on POST form procedure- Social Services Director to initiate POST form upon admission obtaining family/physician signatures. SSD will notify MDS Coordinator and Nurse Management of completion of form. MDS will then care plan POST form. MDS will then notify DON of completion. 3b. On 11/30/2010 DON inserviced MDS Coordinator and MDS Assistant to check for orders for bed/chair alarms upon admission and readmission to facility, during quarterly assessments, and annual assessments and update care plan as needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jan Benson — Administrator — 12/03/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	Continued From page 1 The findings included: Resident #3 was admitted to the facility on September 13, 2007, with diagnoses including Dementia, Diabetes, and Osteoarthritis. Medical record review of the Physician Orders for Scope of Treatment (POST) form, signed by the resident's Power of Attorney (POA) on August 6, 2010, revealed "...Do Not Attempt Resuscitate (DNR/no CPR)..." Medical record review of the Plan of Care dated September 25, 2010, revealed "...In event of cardiorespiratory failure, Begin CPR..." Interview on November 16, 2010, at 1:45 p.m., with the Minimum Data Set Coordinator, in the conference room, confirmed the Plan of Care dated September 25, 2010, was not revised to indicate the DNR status. Resident #8 was admitted to the facility on April 4, 2005, with diagnoses including Hypertension, Dementia, Cardiac Dysrhythmia, Diabetes Mellitus, Osteoarthrosis, Anemia, Depression, Psychosis and Anxiety. Medical record review of a Pre-Restraint Assessment dated August 3, 2010, and updated October 19, 2010, revealed the resident as having "...bed/chair alarm..." Medical record review of the Care Plan updated October 19, 2010, revealed no documentation a bed/chair alarm was required. Observation on November 16, 2010, at 9:30 a.m.,	F 280	F280 483.20 (d)(3), 483.10 (k)(2) from 1 of 6 4a. The DON, Risk Management Nurse, MDS Coordinator and/or Designee will audit resident POST forms upon admission and readmission to facility. The DON, Risk Management Nurse, MDS Coordinator and/or designee will perform random chart audits of residents' POST forms weekly q four weeks until compliance is met. If compliance is not achieved DON will re-inservice and resume weekly audits until substantial compliance is achieved. Audit findings will be reported daily in Leadership morning meeting and monthly in Patient Care and Services meeting. 4b. The DON, Risk Management Nurse, MDS Coordinator and/or Designee will audit Pre-Restraint Assessments upon admission and readmission to facility. The DON, Risk Management Nurse, MDS Coordinator and/or designee will perform random Chart audits of residents' Pre-Restraint Assessments weekly q four weeks until compliance is achieved. If compliance is not achieved DON will re-inservice and resume weekly audits until substantial compliance is achieved. Audit findings will be reported weekly in Leadership morning meeting and monthly in Patient Care and Services meeting.	11/30/2010

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F 280	Continued From page 2 and 1:30 p.m., revealed the resident seated in a wheelchair at the bedside with a personal safety alarm attached. Interview with the ADON (Assistant Director of Nursing), on November 17, 2010, at 10:35 a.m., confirmed the resident was to have a personal alarm in place when in the bed or chair. Interview with the Care Plan Coordinator on November 17, 2010, at 1:45 p.m., confirmed the Care Plan had not been updated to reflect the addition of the personal alarm.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure safety devices were in place for three residents (#6, #13, and #8) of fifteen residents reviewed. The findings included: Resident #6 was admitted to the facility on January 14, 2009, with diagnoses including Dementia, Diabetes, Osteoporosis, and Depression.	F 323	F 323 483.25 (h) SS=D Free of Accident Hazards/Supervision/Devices Requirement: The facility will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision assistance devices to prevent accidents. Corrective Actions: 1a. On 11/16/2010 the DON reviewed care plan of Resident #6 to ensure compliance with "Mobility Alarm when in bed and chair" and applied alarm as ordered. 1b. On 11/17/2010 the DON reviewed care plan of Resident #13 to ensure compliance with "alarm to be on and working when in bed and in chair" and applied alarm as ordered. 1c.On 11/17/2010 the DON reviewed care plan of Resident #8 to ensure compliance with "having bed/chair alarm" and applied alarm as ordered. 2a. On 11/17-11/30/2010 Nurse Management performed audit of care plans and resident care sheets to ensure compliance with bed/chair alarms. 2b. On 11/17-11/30/2010 Nurse Management performed audit of care plans and CNA resident care sheets to ensure compliance with bed/chair alarms. 2c. On 11/17-11/30/2010 Nurse Management Performed audit of Pre-Restraint Assessments to ensure compliance with bed/chair alarms.	

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F 323	Continued From page 3 Medical record review of the Minimum Data Set (MDS) dated October 7, 2010, revealed the resident required limited assistance with transfers and ambulation. Medical record review of a Fall Risk Assessment dated October 8, 2010, revealed the resident was at moderate risk for falls. Medical record review of the Plan of Care dated October 8, 2010, revealed "...Risk for falls/injury...Mobility alarm when in bed & chair..." Observation on November 16, 2010, at 9:10 a.m., revealed the resident seated in a wheelchair, in the hall, without a mobility/safety alarm in place. Observation and interview on November 16, 2010, at 9:17 a.m., with Licensed Practical Nurse (LPN) #1, revealed the resident sitting in the wheelchair, in the hallway, and confirmed the mobility/safety alarm was not in place. Resident #13 was admitted to the facility on September 25, 2007, with diagnoses including Alzheimer's Disease, Osteoarthritis, and Hypertension. Medical record review of the MDS dated July 7, 2010, revealed the resident had severely impaired cognitive skills, and required extensive assistance with transfers and walking. Medical record review of a Fall Risk Assessment dated August 25, 2010, revealed the resident was at high risk for falls. Medical record review of the Plan of Care dated July 8, 2010, revealed "...At risk for injury...Alarm	F 323	F 323 483.25 (h) con't from page 3 of 6 3. On 11/22 & 30/2010, and 12/3/2010, the DON Inserviced licensed and certified nursing staff on bed/chair alarm/mobility alarm procedures. 4.The facility DON, Risk Management, and/or Designee will audit resident charts q daily in Leadership morning meeting for compliance with bed/chair alarm/mobility alarm procedures. DON, Risk Management, and/or designee will audit weekly q three months until compliance is achieved. If compliance is not achieved DON will re-inservice and resume weekly audits until substantial compliance is met. Audit findings will be reviewed monthly in the Fall/ Restraint Meeting and quarterly in QA & QI Meeting.	12/03/201(

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F 323	Continued From page 3 Medical record review of the Minimum Data Set (MDS) dated October 7, 2010, revealed the resident required limited assistance with transfers and ambulation. Medical record review of a Fall Risk Assessment dated October 8, 2010, revealed the resident was at moderate risk for falls. Medical record review of the Plan of Care dated October 8, 2010, revealed "...Risk for falls/injury...Mobility alarm when in bed & chair..." Observation on November 16, 2010, at 9:10 a.m., revealed the resident seated in a wheelchair, in the hall, without a mobility/safety alarm in place. Observation and interview on November 16, 2010, at 9:17 a.m., with Licensed Practical Nurse (LPN) #1, revealed the resident sitting in the wheelchair, in the hallway, and confirmed the mobility/safety alarm was not in place. Resident #13 was admitted to the facility on September 25, 2007, with diagnoses including Alzheimer's Disease, Osteoarthritis, and Hypertension. Medical record review of the MDS dated July 7, 2010, revealed the resident had severely impaired cognitive skills, and required extensive assistance with transfers and walking. Medical record review of a Fall Risk Assessment dated August 25, 2010, revealed the resident was at high risk for falls. Medical record review of the Plan of Care dated July 8, 2010, revealed "...At risk for injury...Alarm	F 323	F 323 483.25 (h) con't from page 3 of 6 3. On 11/22 & 30/2010, and 12/3/2010, the DON Inserviced licensed and certified nursing staff on bed/chair alarm/mobility alarm procedures. On 12/07/2010 DON inserviced ADON, Risk Mgt. Nurse and Staffing Coordinator on facility rounds to ensure compliance per personal alarms/care plans. DON, ADON, Risk Mgt. Nurse and Staffing Coordinator will ensure bed/chair alarms are in place and functioning properly during daily rounds Monday thru Friday. In absence of Nurse Mgt., Facility Charge Nurses will monitor placement and function of bed/chair alarms and document on resident MAR qday/qshift. Maintenance Supervisor and/or designee will ensure compliance with bed/chair alarms q weekend per placement and function of bed/chair alarms. 4.The facility DON, Risk Management, and/or Designee will audit resident charts q daily in Leadership morning meeting for compliance with bed/chair alarm/mobility alarm procedures. DON, Risk Management, and/or designee will audit weekly q three months until compliance is achieved. If compliance is not achieved DON will re-inservice and resume weekly audits until substantial compliance is met. Audit findings will be reviewed monthly in the Fall/ Restraint Meeting and quarterly in QA & QI Meeting.	12/22/2010

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F 323	Continued From page 4 to be on and working when in bed and in chair..." Medical record review of a Nurse's Event Note dated August 25, 2010, at 9:15 a.m., revealed "...Walked in to find resident setting in floor. No apparent injury...Immediate Steps Implemented to Prevent Recurrence: All alarms to be on...when in chair and in bed..." Observation on November 17, 2010, at 2:25 p.m., revealed the resident lying on the bed with a safety alarm in place. Interview on November 17, 2010, at 3:15 p.m., with the Assistant Director of Nursing, in the nursing office, confirmed the safety alarm was not in place at the time of the fall on August 25, 2010. Resident #8 was admitted to the facility on April 4, 2005, with diagnoses including: Hypertension, Dementia, Cardiac Dysrhythmia, Diabetes Mellitus, Osteoarthrosis, Anemia, Depression, Psychosis and Anxiety. Medical record review of the Pre-Restraint Assessment, dated August 3, 2010 and updated October 19, 2010, revealed the resident as having "...bed/chair alarm..." Observation on November 17, 2010, at 9:35 a.m., revealed the resident sitting up in a wheelchair at the bedside. The personal safety alarm was lying in a recliner behind the resident's wheelchair, not attached to the resident. Observation and interview on November 17, 2010, at 9:45 a.m., with LPN (Licensed Practical Nurse) #3, revealed the resident seated in a	F 323		

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F 323	Continued From page 5 wheelchair, and confirmed a chair alarm was to be used when the resident was seated in the wheelchair. Continued interview with LPN #3 confirmed the personal safety alarm was not attached to the resident.	F 323		